PRINCE GEORGE'S COUNTY

Selection of Focus Area

Prince George's County has identified a number of important focus areas as primary public health concerns. They include: communicable disease control (STDs, TB, HIV/AIDS, rabies in animals, vaccine preventable diseases, food-borne diseases); substance abuse/mental health (addictions/mental health treatment services to women, children, adolescents and families); and access to care (expanding Healthline, other outreach activities, and community-based programs).

Additionally, infrastructure improvement and strategic health planning, including improvement of data management capabilities, have been included, along with reducing infant mortality, as areas to be included in the Health Improvement Plan.

DEMOGRAPHIC OVERVIEW

Estimated Population, by Race – 1998

Total	777,810
White	37.4%
Other	62.6%

Estimated Population, by Age – 1998

Under 1	11,940	18-44	359,020
1-4	42,560	45-64	158,520
5-17	144,170	65+	61,600

All causes Mortality Rate (age-adjusted, per 100,000 population) 1996-1998	552.4
Infant Mortality Rate 1995-1999	12.0
Estimated Mean Household Income – 1999	$61,700
Estimated Median Household Income – 1999	$54,600
Civilian Unemployment Rate, Annual Average – 1999	3.5

Labor force (Top 4) – 1995

Services	107,600	Retail Trade	74,200
Government (Federal, Military)	83,800	State & Local	51,600

Sources: Maryland Vital Statistics, 1999
Maryland Department of Planning, 1995, 1998, 1999

Focus Area 1 - Reducing Infant Mortality in Prince George's County

Problem

The death of an infant is considered an important indicator of health for a community. Over the past decade the infant mortality rate (IMR) in Maryland has been declining; however, the decline has been greater for white infants than for African-American infants. For every jurisdiction in Maryland and for the Nation as a whole, there remains a tremendous disparity in race-specific infant mortality rates (see graph), with African-American infants being more than twice as likely to die in the first year of life than their white counterparts.

In 1998, the IMR for white infants in Prince George's County (7.9) was higher than the Maryland rate (5.5) and the National rate (6.0) for white infants. Similarly, the IMR for African-American infants in Prince George's County (15.5) was higher that the State rate (15.3) and the National rate (14.1) for African-American infants. In Maryland, the leading cause of death for white infants is congenital anomalies, followed by low birth weight, maternal complications and respiratory distress syndrome. In contrast, the leading cause of death for African-American infants is low birth weight, followed by Sudden Infant Death Syndrome (SIDS) and congenital anomalies.

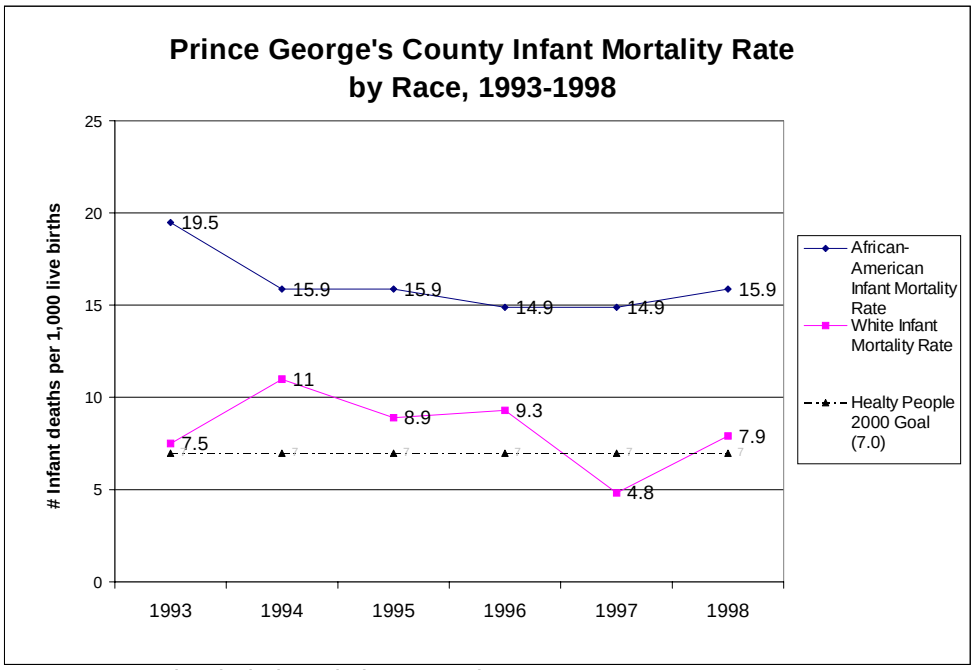
Determinants

Among many factors associated with infant mortality, low birth weight is considered to be one of the most significant. In 1998, 1,244 Prince George's County babies (10.2% of the births) were born weighing less than five and one half pounds (2500 grams). More African-American babies had low birth weight (11.7% of births to African-Americans) than white babies (7.0% of births to white women). In Prince George's County, more than half of the infants who die each year are born very prematurely weighing less than 750 grams, a weight that corresponds to approximately 26 weeks of gestation. A key to reducing infant mortality in the County is to reduce the number of pregnancies that result in premature delivery and a very low birth weight infant.

Lack of early and appropriate prenatal care for pregnant women, particularly women who are at increased medical or social risk for poor pregnancy outcome, is also associated with poor pregnancy outcomes. In Prince George's County, in 1998, 77.8% of women giving birth received prenatal care in their first trimester. Disparities, however, existed between African-American and white women in this characteristic; 75.5% of African-American women, as opposed to 86.6% of white women, received prenatal care in their first trimester. The Healthy People 2000 goal is to increase to at least 90% the proportion of all pregnant women who begin prenatal care in their first trimester of pregnancy.

Sudden Infant Death Syndrome (SIDS) and other health factors are also associated with infant mortality. In 1998, 15 of the infant mortality cases in Prince George's County were attributed to congenital anomalies, and 14 to SIDS. Data from the "Study on the Impact of Managed Care on Access to Quality of Prenatal Care in Maryland" conducted by the Maryland Commission on Infant Mortality Prevention in 1997 indicates that among 349 women enrolled in either Medicaid

or commercial managed care programs who participated in the study, 70% of the Medicaid mothers reported that their pregnancies were unintended. The Healthy People 2000 goal is to reduce to no more that 40% the proportion of all pregnancies that are unintended. This study also showed that Medicaid mothers had more inadequate prenatal care than mothers enrolled in commercial managed care with regard to initiation of prenatal care and the number of prenatal visits. Substance abuse may also increase the risk of poor pregnancy outcomes, especially low and very low birth weights. Data from the Health Department's Infant At Risk Program, which provides services to at-risk pregnant women and mother-infant pairs, shows that of the 1,257 referrals made to this program in 1998, 218 (17%) women had substance abuse as a risk factor, and 283 (23%) reported having had no prenatal care. Prince George's Hospital Center statistics for this same year indicate that among the 2,840 infants delivered at the Hospital Center, there were 919 (32%) referrals to the Infant At Risk Program, and 124 of the mothers referred (13.5%) had a history of or a positive toxicology screen for substance abuse.



Source: Maryland Vital Statistics Annual Reports, 1993-1998

It is important to note that for many of the factors associated with infant mortality, accurate County specific data are often not available, for various reasons. Systems and procedures do not yet exist for capturing some of the needed data, not all health care providers are adequately trained or otherwise able to conduct thorough patient histories, and resources are insufficient to follow-up patients and providers to ensure that reports are accurate and complete. Consequently, even basic information such as client race, maternal education, parental alcohol and other substance abuse, birth weight, and other information may be inaccurately reported or altogether missing from crucial documents such as infant birth and death certificates. Data from medical record reviews of fetal and infant deaths are currently derived from too small a client population (30 record reviews in 1998, for example) to be able to draw conclusions or make recommendations for future action; however, these data suggest that factors such as pre-existing gynecological, nutritional and other health problems among women who lost their infants warrant additional study. Confounding the problem with data is the fact that approximately 59% of pregnant women who reside in Prince George's County deliver outside the County. Inaccurate or missing data continue to pose a significant problem for providers involved in planning strategies to address infant mortality in Prince George's County.

Objective 1 - By 2005, increase to at least 90% the proportion of all pregnant women in Prince George's County who begin prenatal care in the first trimester of pregnancy. (Baseline: 77.8% in 1998)

Action Steps

- ⇨ Conduct a community-wide multi-strategy information campaign to inform pregnant women of the importance of prenatal care and the resources available to them.

- ⇨ Use non-traditional approaches/sources such as beauty/nail salons, movie theatres, motor vehicle registration offices, housing complexes, businesses, churches, etc., as well as culturally competent resources (i.e. peer and near peer educators for adolescents, resource mothers, health promoters for Spanish speaking communities) to carry out or support educational/information programs promoting early and continuous prenatal care, and to assist pregnant women in obtaining prenatal care and other services.

- ⇨ Work with Members of the Catholic Charities Medical Care Community Partnership (MCCP) and other health/human service organizations to ensure that parents of children eligible for government health insurance programs receive medical coverage as well.

- ⇨ Work with the schools, the Health Department's Healthy Teens and Young Adults Program, Planned Parenthood, and other private and public resources to develop strategies to enroll pregnant adolescents and adolescents with children in the Maryland Children's Health Program (MCHP), and to ensure that pregnant adolescents receive early and on-going prenatal care.

- ⇨ Coordinate efforts with the Department of Social Services and other health and human service organizations to ensure that eligible pregnant women receive health insurance by enrolling in MCHP, information about the importance of prenatal care, and referrals to needed prenatal care and other services.

- ⇨ Through active membership on the Fetal and Infant Mortality Review (FIMR) Technical Review and Community Action Panels, strengthen linkages and coordination of services with existing community partners serving pregnant women and women of childbearing age. Identify new partners, such as correctional facilities, emergency room personnel, academic institutions, public and private school officials, county/municipal police departments, parks and recreation departments, pharmaceutical companies and pharmacies, religious leaders/organizations, community counseling services, census officials, dental care providers, etc., who can participate in the community effort to reduce infant mortality.

- ⇨ Coordinate efforts with local programs funded through the tobacco restitution initiative, substance abuse mini-grants, and the Centers for Disease Control and Prevention's (CDC) HIV/AIDS prevention grants, to promote prenatal care and eliminate the use of tobacco, alcohol, and illicit drugs by pregnant women.

- ⇨ Survey health and human service providers to determine the extent to which they can provide culturally and linguistically competent pre-conception, prenatal, and post-natal care to the County's diverse populations (i.e. diversity of staff, multilingual capabilities, appropriate educational materials and strategies).

- ⇨ Work with existing resources to identify strategies for involving fathers in promoting prenatal care for their pregnant partners.

- ⇨ Ensure that all women receiving pregnancy testing also receive education/information on the importance of prenatal care.

- ⇨ Continue promoting Healthline, a Health Department-sponsored toll-free telephone information, referral, and appointment setting service, to enhance access to care for pregnant women.

Objective 2 - By 2005, increase to at least 90% the proportion of all live born infants whose mothers receive prenatal care that is adequate or more than adequate according to the adequacy of Prenatal Care Utilization Index. (Developmental objective: no County-specific data exists.)

Action Steps

- ⇨ Conduct research to identify programs that have been successful in reducing infant mortality to determine program components that may be applicable to the County.

- ⇨ Ensure that all pregnant women with identifiable risks are offered case management services.

- ⇨ Conduct focus groups to learn more about women's perceptions of prenatal care and the barriers to accessing care, their knowledge of available services, and to obtain their ideas for improving the service delivery system.

Objective 3 - By 2005, reduce to 30% or less the proportion of all pregnancies among women ages 15 to 44 that are unintended. (Baseline: 70% of pregnancies among women participating in the Study on the Impact of Managed Care on Prenatal Care in 1997– see previous reference–were unintended.)

Action Steps

- ⇨ Provide age-specific and culturally/linguistically sensitive family planning materials in clinics and community settings throughout the County.

- ⇨ Promote public education about the benefits of family planning/contraception.

- ⇨ Strengthen linkages and coordination of services with existing community partners serving women of childbearing age (particularly MCHP recipients and adolescents) to ensure their unconditional access to and on-going family planning services throughout the childbearing years. Identify new partners, such as correctional facilities, academic institutions, pharmaceutical companies, religious leaders/organizations, community counseling services, etc., who can participate in the community effort to promote family planning.

- ⇨ Use non-traditional approaches/sources such as beauty/nail salons, movie theaters, motor vehicle registration offices, housing complexes, businesses, churches, etc., as well as culturally competent resources (i.e. peer and near peer educators for adolescents, resource mothers, health promoters for Spanish speaking communities) to carry out or support educational/information programs promoting use of family planning/contraceptive services.

- ⇨ Identify strategies to increase male involvement in family planning programs.

- ⇨ Continue promoting Healthline to enhance access to family planning services for women of childbearing age and their male partners.

Objective 4 - By 2005, improve the quality and type of data collected on infant births and deaths in Prince George's County in order to fill current gaps in information and achieve a greater understanding of the underlying risk factors associated with infant mortality, including social, environmental, and other community conditions .

Action Steps

- ⇨ Work with the Department of Health and Mental Hygiene, maternal and child health providers, and other health/human service organizations to identify current data gaps and future data needs, to identify and tap available data sources and technology, and to establish systems and procedures for collecting/obtaining and disseminating needed data related to infant mortality.

- ⇨ Utilize the findings of the FIMR Technical Review Panel to identify specific areas where information is lacking and to begin developing a more complete profile of mothers and fathers who lose their babies.

- ⇨ Utilize home visitors or resource mothers to work with families who have lost babies in order to obtain information that is missing in reports on infant deaths.

- ⇨ Use surveys, focus groups, or other assessment strategies with pregnant women (particularly women at risk of poor pregnancy outcomes) to gain information on the underlying risk factors associated with infant mortality.

Partners

American Association of University Women Identity, Inc. • Current Partners in the Prince George's County Fetal and Infant Mortality (FIMR) Technical Review and Community Action Panels • Family Advocacy Network • Maryland Department of Health and Mental Hygiene • Members of the Catholic Charities Medical Care Community Partnership (MCCP) • Mid-Atlantic Association of Community Health Centers • Pregnancy Aid Center • Prince George's Child Resource Center • Prince George's County Department of Family Services • Prince George's County Health Department • Prince George's County Local Management Boards • Prince George's Foundation • Prince George's Hospital Center • Priority Partners • Progressive Life Center • Southern Management Corporation • Spanish Catholic Center • Summit Health Institute for Research and Evaluation (SHIRE)

Focus Area 2 - Enhancing Infrastructure for Health Planning

Problem/Determinants

Beginning in 1991, the Prince George's County Health Department experienced significant reductions in County funding resulting from voter-imposed limitations on the County's taxing authority. To accommodate the loss of funds while maintaining essential public health services, Health Department Divisions were reduced, and highly-valued clinical, preventive, and specialty services were eliminated. During this time, the Health Department's planning functions were essentially "reactive," in that the agency was forced to reassess its priorities, shut down programs, restructure remaining services, and redirect and retrain staff. While the agency continued to monitor health trends, collect and analyze vital statistics, surveillance, and morbidity data, and track consensus indicators and leading causes of death, it lacked the professional, financial, and other resources necessary to carry out fundamental health planning activities such as community needs assessments.

While the period of downsizing was difficult, the Health Department emerged in the mid-1990s with a renewed focus on fulfilling its core public health and safety functions, including planning and assessment. The Division of Program Planning and Evaluation was created, and was assigned responsibility for agency-wide data management, strengthening relationships with community groups, the media, and other government agencies, and managing the Ryan White Title I planning process and grants for Suburban Maryland. Having laid the groundwork for on-going strategic health planning, the public information and planning functions of this Division were eventually incorporated into the Office of the Health Officer, and a Health Planner was hired in September 1999. The Health Department is currently making plans to undertake a community-wide needs assessment during the next eight to 10 months, to enhance its community partnerships, and to carry out other health planning activities as outlined in the Health Department's Local Health Plan for Fiscal Year 2000.

The goal is to establish by 2003 an ongoing strategic health planning process which:

- Is supported by up-to-date health related data and other scientifically sound evidence;
- Involves a broad range of community participants and engages the community to take action; and
- Results in the development of annual health improvement plans that are consistent with the Department of Health and Mental Hygiene's health planning efforts, the State Health Improvement Plan (HIP), and the Healthy People 2010 Initiative.

Objective 1 - By 2001, complete a formal community-wide needs assessment and establish an ongoing needs assessment process through which local health needs and priorities are identified and reflected in the local health improvement plan.

Action Steps

- ⇨ Hire a consultant/contractor to plan and carry out a comprehensive community needs assessment, to analyze the data, and formulate recommendations for the Health Department.

- ⇨ Facilitate meetings of community partners to guide the needs assessment process and develop a system for ongoing strategic health planning.

- ⇨ Hire additional health planning staff to coordinate health planning activities.

Objective 2 - By 2003, improve the Health Department's data/public health information management capabilities to ensure that the health data collected is timely, accurate, accessible to interested individuals and community organizations, and relevant to the Health Department for reporting on health status and health system improvements.

Action Steps

- ⇨ Fill the vacant biostatistician position.

- ⇨ Develop new and/or upgrade existing public health data systems and technology (i.e Geographic Information System), and train all Health Department staff assigned to data collection and management functions in their proper use.

- ⇨ Organize available health data to enhance their usefulness for health planning purposes (i.e. multi-year, jurisdictional, age group, and ethnic/demographic aggregates; race-adjusted rates, disparity comparisons, adjustments for small populations, and low incidence).

- ⇨ Work with DHMH and other Local Health Departments to identify current health information gaps, future data needs, data sources and technology, and to establish systems and procedures for collecting/obtaining and disseminating needed health information.

Objective 3 - By 2001, establish a network of community partners reflecting the diversity of Prince George's County who will be involved on a continuous basis in strategic health planning activities for the purposes of developing strategies, policies, and programs to address community health needs.

Action Steps

- ⇨ Train health planning staff in community development techniques to enhance their skills in community network/partnership development.

- ⇨ Expand the network of existing community partners to include representatives from culturally, linguistically, and ethnically diverse populations of Prince George's County, as well as non-traditional participants such as business, religious, and media representatives.

- ⇨ Hold regularly scheduled network meetings throughout the year to engage partners in specific health planning activities, and to carry out recommendations from the formal needs assessment.

Objective 4 - By 2003, develop annual health improvement plans that reflect local needs and priorities identified through a formal needs assessment, and are linked with the State's Health Improvement Plan (HIP).

Action Steps

- ⇨ Present results of the formal needs assessment to community partners and Health Department Directors to begin formulating health priorities, programs, policies.

- ⇨ Work with Directors of each Health Department Division to develop their sections of the local health improvement plan.

- ⇨ Continue serving on the Local Health Planning Advisory Committee and with other DHMH planning committees to coordinate local health planning efforts and the development of the local health improvement plan with the State's HIP.

Partners

Will be identified through the formal needs assessment process, and will include representatives from hospitals, nursing home/assisted living facilities, other health and human service organizations, academic institutions, current Health Department grant recipients, community-based organizations, consumers, interested citizens, and non-traditional partners.

Related Reports

American Public Health Association. (1991). Healthy Communities 2000: Model Standards (3rd ed.). American Public Health Association.

Maryland Department of Health and Mental Hygiene. (1999, May). *Summit report.* From Healthy Maryland Project 2010: Integrated Health Planning Summit.

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U.S. Department of Health and Human Services. (1998, September). *Healthy People 2010 objectives* (Draft). Report draft. Washington, DC: U.S. Department of Health and Human Services, U.S. Government Printing Office.

Cross-Reference Table for Prince George's County

See Also

Child and Adolescent Health 33
Maternal and Infant Health 96
Public Health Infrastructure 115